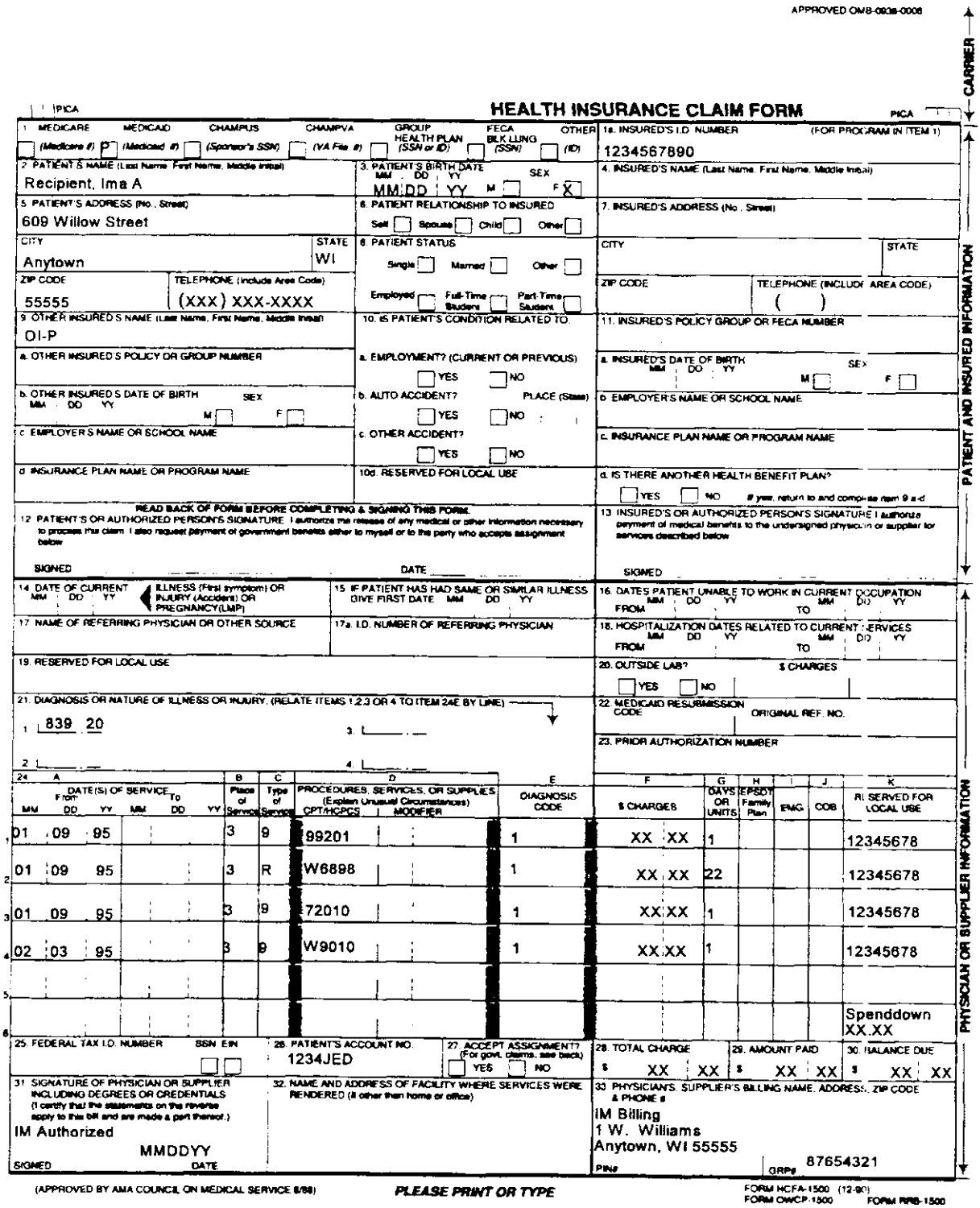
Chiropractic Services
Appendices

Page #

Appendix 1
Sample HCFA 1500 Claim Form



APPROVED OMB-0938-0008

PICA — **HEALTH INSURANCE CLAIM FORM** — PICA

CARRIER

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 1234567890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Ima A

3. PATIENT'S BIRTH DATE MM DD YY: MM DD YY — SEX: M ☐ F ☒

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 609 Willow Street

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street):

CITY: Anytown — STATE: WI

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐ — Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY: — STATE:

ZIP CODE: 55555 — TELEPHONE (Include Area Code): (XXX) XXX-XXXX

ZIP CODE: — TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): OI-P

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☐

a. INSURED'S DATE OF BIRTH MM DD YY — SEX: M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY — SEX: M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☐ PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES ☐ NO ☐

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☐ If yes, return to and complete item 9 a-d

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY — FROM TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY — FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 839 20
2.
3.
4.

22. MEDICAID RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24 A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. Place of Service	C. Type of Service	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS CODE	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. EMG	J. COB	K. RESERVED FOR LOCAL USE
1 01 09 95		3	9	99201		1	XX XX	1				12345678
2 01 09 95		3	R	W6898		1	XX XX	22				12345678
3 01 09 95		3	9	72010		1	XX XX	1				12345678
4 02 03 95		3	9	W9010		1	XX XX	1				12345678
5												
6												Spenddown XX.XX

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.: 1234JED

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. TOTAL CHARGE: $ XX XX

29. AMOUNT PAID: $ XX XX

30. BALANCE DUE: $ XX XX

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
IM Authorized
MMDDYY
SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
IM Billing
1 W. Williams
Anytown, WI 55555
PIN# GRP# 87654321

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 6/88) **PLEASE PRINT OR TYPE** FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

Appendix 1a
Sample Electronic Media Screen

05/05/95
VL1

HCFA 1500 (CT 20, 21, 24, 30)

* *

MEDICAL ECS SCREEN
The field numbers on the ECS screen correspond with the numbered data elements on the HCFA 1500 claim form.

WELCOME TO ELECTRONIC CLAIMS SUBMISSION DATE 010193
EDS - WISCONSIN MEDICAID

BP NBR 33 L NAME 2 F NAME 2 MID 1A
PCN 26 OI 9 TPL 10 MSC 11 PA NBR 23 LAB 20
RP NBR 17 FP NBR 32 OP NBR ____
DIAG 1 21.1 2 21.2 3 21.3 4 21.4 5 ____

DTL	FDOS	A1A2A3	POS	PROC	M1	M2	PP NBR	DX	CHARGE	UNIT	TOS	EMG	H/F
1	24.A	A	B	D	D	D	K	E	F	G	C	I	H
2													
3													
4													
5													
6													
7													
8													
9													
10													

TOT BILL 28 OI PAID 29 PAT PAID 24.K NET BILL 30

Doc #1 Page #1 Field #6 Form: MEDICAL 06-01-1992 10:16:34

Form	CT	Description
MEDICAL	20	Chiropractor Services Family Planning Clinics Rural Health Clinics Laboratory, X-ray, Radiology Free Standing Ambulatory Surgical Centers Physician Services Non-51.42 Owned & Operated Mental Health, AODA, Day Treatment Case Management Community Support Program Podiatry Services Prenatal Care Coordination HealthCheck

Appendix 2
HCFA 1500 Claim Form Completion Instructions for Chiropractic Services

Use these claim form completion instructions to avoid denial or inaccurate claim payment. Enter all required data on the claim form in the appropriate element. Include attachments only when asked to do so. All elements are required unless "not required" is specified.

Wisconsin Medicaid recipients receive an identification card when initially enrolled into Wisconsin Medicaid and at the beginning of each following month. Providers should always see this card before rendering services. Please use the information exactly as it appears on the identification card to complete the patient and insured information.

Element 1 - Program Block/Claim Sort Indicator
Enter claim sort indicator "P" in the Medicaid check box. Claims submitted without this indicator are denied.

Element 1a - Insured's ID Number
Enter the recipient's 10-digit Wisconsin Medicaid identification number from the current identification card. Do not enter any other numbers, unless the claim is a Medicare crossover claim, in which case the recipient's Medicare number may also be entered.

Element 2 - Patient's Name
Enter the recipient's last name, first name, and middle initial from the current identification card.

Element 3 - Patient's Birth Date, Patient's Sex
Enter the recipient's birth date in MM/DD/YY format (e.g., February 3, 1955, would be 02/03/55) from the identification card. Specify if male or female with an "X."

Element 4 - Insured's Name (not required)

Element 5 - Patient's Address
Enter the complete address of the recipient's place of residence.

Element 6 - Patient relationship to Insured (not required)

Element 7 - Insured's Address (not required)

Element 8 - Patient Status (not required)

Element 9 - Other Insured's Name
Bill health insurance (commercial insurance coverage) before billing Wisconsin Medicaid, unless the service does not require health insurance billing according to Appendix 18a of Part A of the provider handbook.

- Leave this element blank when the provider has not billed health insurance because the "Other Coverage" on the recipient's identification card is blank, the service does not require health insurance billing according to Appendix 18a of Part A of the provider handbook, or the recipient's identification card indicates "DEN" only.

- When "Other Coverage" on the recipient's identification card indicates HPP, BLU, WPS, CHA, DEN, or OTH, and the service requires health insurance billing according to Appendix 18a of Part A of the provider handbook, indicate one of the following codes in the *first* box of element 9. The description is not required, nor is the policyholder, plan name, group number, etc. (Elements 9a, 9b, 9c, and 9d are not required.)

Code	***Description***
OI-P	PAID in part by the health insurance. The amount paid by the health insurance to the provider or

the insured is indicated on the claim.

OI-D DENIED by the health insurance following submission of a correct and complete claim or payment was applied towards the coinsurance and deductible. Do NOT use this code unless the claim in question was actually billed to and denied by the health insurer.

OI-Y YES, card indicates health insurance but it was not billed for reasons including, but not limited to:

- recipient denies coverage or will not cooperate;
- the provider knows the service in question is noncovered by the carrier.
- health insurance carrier failed to respond to initial and follow-up claim; or
- benefits not assignable or cannot get an assignment.

- When "Other Coverage" on the recipient's identification card indicates "HMO" or "HMP", indicate one of the following disclaimer codes, if applicable:

Code	*Description*
OI-P	PAID by HMO or HMP. The amount paid is indicated on the claim.
OI-H	HMO or HMP does not cover this service or the billed amount does not exceed the coinsurance or deductible amount.

Important Note: The provider may *not* use OI-H if the HMO or HMP denied payment because an otherwise covered service was not rendered by a designated provider. Wisconsin Medicaid does not pay for services covered by an HMO or HMP except for the copayment and deductible amounts. Providers who receive a capitation payment from the HMO may not bill for services which are included in the capitation amount.

Element 10 - Is Patient's Condition Related To (not required)

Element 11 - Insured's Policy, Group or FECA Number
The *first* box of this element is used by Wisconsin Medicaid for Medicare information. (Elements 11a, 11b, 11c, and 11d are not required.) Medicare must be billed before billing to Wisconsin Medicaid. When the recipient's identification card indicates Medicare coverage, but Medicare does not pay, indicate one of the following Medicare disclaimer codes. The description is not required.

Code	*Description*
M-1	Medicare benefits exhausted. This disclaimer code may be used by hospitals, nursing homes, and home health agencies when Medicare has made payment up to the lifetime limits of its coverage.
M-5	Provider not Medicare-certified for the benefits provided.
M-6	Recipient not Medicare eligible.
M-7	Medicare disallowed (denied) payment. Medicare claim cannot be corrected and resubmitted.
M-8	Medicare was not billed because Medicare never covers this service.

If Medicare is not billed because the recipient's identification card indicates no Medicare coverage, leave this element blank.

If Medicare allows an amount on the recipient's claim, attach the Explanation of Medicare Benefits (EOMB) to the claim and leave this element blank. Do not enter Medicare paid amounts on the claim form. Refer to Appendix 17 of Part A of the provider handbook for more information about submitting claims for dual entitlees.

Elements 12 and 13 - Authorized Person's Signature
(Not required since the provider automatically accepts assignment through Wisconsin Medicaid certification.)

Element 14 - Date of Current Illness, Injury, or Pregnancy (not required)

Element 15 - If Patient has had Same or Similar Illness (not required)

Element 16 - Dates Patient Unable to Work in Current Occupation (not required)

Element 17 - Name of Referring Physician or Other Source (not required)

Element 17a - ID Number of Referring Physician (not required)

Element 18 - Hospitalization Dates Related to Current Services (not required)

Element 19 - Reserved for Local Use
If an unlisted procedure code is billed, providers must describe the procedure. If element 19 does not provide sufficient space for the procedure description, or if multiple unlisted procedure codes are being billed, attach documentation to the claim describing the procedure(s). In this instance, providers must indicate "See Attachment" in element 19.

Element 20 - Outside Lab
If a laboratory handling fee is billed, check "yes" to indicate that the specimen was sent to an outside lab.

Element 21 - Diagnosis or Nature of Illness or Injury
Enter an allowable diagnosis code. Refer to Appendix 3 of this handbook for allowable chiropractic diagnosis codes.

Element 22 - Medicaid Resubmission (not required)

Element 23 - Prior Authorization
Enter the seven-digit prior authorization number from the approved prior authorization request form. Bill services authorized under multiple prior authorizations on separate claim forms with their respective prior authorization numbers.

Element 24a - Date(s) of Service
Enter the month, day, and year for each procedure using the following guidelines:

- When billing for one date of service, enter the date in MM/DD/YY format in the "FROM" field.

- When billing for two, three, or four dates of service on the same detail line, enter the first date of service in MM/DD/YY format in the "FROM" field, and subsequent dates of service in the "TO" field by listing *only* the date(s) of the month (i.e., DD, DD/DD, or DD/DD/DD).

It is allowable to enter up to four dates of service per line if:

- All dates of service are in the same calendar month.
- All services are billed using the same procedure code and modifier, if applicable.
- All procedures have the same type of service code.
- All procedures have the same place of service code.
- All procedures were performed by the same provider.
- The same diagnosis is applicable for each procedure.
- The charge for all procedures is identical. (Enter the total charge *per detail line* in element 24F.)
- The number of services performed on each date of service is identical.
- All procedures have the same HealthCheck or family planning indicator.

- All procedures have the same emergency indicator.

Element 24b - Place of Service
Enter the appropriate *single-digit* place of service code for each service. Refer to Appendix 4 of this handbook for a list of allowable place of service codes.

Element 24c - Type of Service Code
Enter the appropriate single-digit type of service code. Refer to Appendix 4 of this handbook for list of allowable type of service codes.

Element 24d - Procedures, Services, or Supplies
Enter the appropriate five-character procedure code and, if applicable, a maximum of two, two-character modifiers under the "Modifier" column. Refer to Appendix 5 of this handbook for a list of Wisconsin Medicaid-allowable procedure codes for chiropractic services.

Element 24e - Diagnosis Code
When multiple procedures related to different diagnoses are submitted, use column E to relate the procedure performed (element 24D) to a specific diagnosis in element 21. Enter the number (1, 2, 3, or 4) which corresponds to the appropriate diagnosis in element 21.

Element 24f - Charges
Enter the total charge for each line item.

Element 24g - Days or Units
Enter the total number of services billed for each line item. Indicate a decimal only when a fraction of a whole unit is billed.

Element 24h - EPSDT/Family Planning
Enter an "H" for each procedure that was performed as a result of a HealthCheck (EPSDT) referral. Enter an "F" for each family planning procedure. Enter a "B" if *both* HealthCheck and family planning services were provided. If HealthCheck or family planning do not apply, leave this element blank.

Element 24i - EMG
Enter an "E" for *each* procedure performed as an emergency, regardless of the place of service. If the procedure is not an emergency, leave this element blank.

Element 24j - COB (not required)

Element 24k - Reserved for Local Use
Enter the eight-digit provider number of the performing provider *for each procedure*, if it is different than the billing provider number indicated in element 33.

When applicable, enter the word "spenddown" and under it the spenddown amount on the last detail line of element 24K directly above element 30. Refer to Section IX of Part A of the provider handbook for information on recipient spenddown.

Any other information entered in this element may cause claim denial.

Element 25 - Federal Tax ID Number (not required)

Element 26 - Patient's Account No.
*Optiona*l - a provider may enter up to 12 characters of the patient's internal office account number. This number appears on the fiscal agent's Remittance and Status Report.

Element 27 - Accept Assignment
(Not required, provider automatically accepts assignment through Wisconsin Medicaid certification.)

Element 28 - Total Charge
Enter the total charges for this claim.

Element 29 - Amount Paid

Enter the amount paid by other insurance. If the other insurance denied the claim, enter $0.00. (If a dollar amount is enter in element 29, enter "OI-P" in element 9.)

Element 30 - Balance Due

Enter the balance due as determined by subtracting the recipient spenddown amount in element 24K and the amount paid in element 29 from the amount in element 28.

Element 31 - Signature of Physician or Supplier

The provider or the authorized representative must sign in element 31. Also enter the month, day, and year the form is signed (in MM/DD/YY format).

> ***Note:*** This may be a computer-printed or typed name and date, or a signature stamp with the date.

Element 32 - Name and Address of Facility Where Services Rendered

If the services were provided to a recipient in a nursing home (place of service 7 or 8), indicate the nursing home's eight-digit provider number.

Element 33 - Physician's, Supplier's Billing Name, Address, ZIP Code and Phone

Enter the provider's name (exactly as indicated on the provider's notification of certification letter) and address of the billing provider. At the bottom of element 33, enter the billing provider's eight-digit provider number.

Appendix 3
Diagnostic Codes

Intervertebral Disc Disorders

722.0 Displacement of cervical intervertebral disc without myelopathy Neuritis (brachial) or radiculitis due to displacement or rupture of cervical intervertebral disc

722.1 Displacement of thoracic or lumbar intervertebral disc without myelopathy

722.10 Lumbar intervertebral disc without myelopathy
Lumbago or sciatica due to displacement of intervertebral disc
Neuritis or radiculitis due to displacement or rupture of lumbar intervertebral disc
Any condition classifiable to 722.2 of the lumbar or lumbosacral intervertebral disc

722.11 Thoracic intervertebral disc without myelopathy
Any condition classifiable to 722.2 of thoracic intervertebral disc

722.2 Displacement of intervertebral disc, site unspecified without myelopathy
Discogenic syndrome NOS
Herniation of nucleus pulposus NOS
Intervertebral is NOS:
extrusion
prolapse
protrusion
rupture
Neuritis or radiculitis due to displacement or rupture of intervertebral disc

Other, Multiple, and Ill-Defined Dislocations

839.0 Cervical vertebra, closed
Cervical spine neck

839.00 Cervical vertebra, unspecified

839.01 First cervical vertebra

839.02 Second cervical vertebra

839.03 Third cervical vertebra

839.04 Fourth cervical vertebra

839.05 Fifth cervical vertebra

839.06 Sixth cervical vertebra

839.07 Seventh cervical vertebra

839.08 Multiple cervical vertebrae

839.2 Thoracic and lumbar vertebra, closed

839.20 Lumbar vertebra

839.21 Thoracic vertebra
Dorsal (thoracic) vertebra

839.4 Other vertebra, closed

839.40	Vertebra, unspecified site Spine NOS
839.41	Coccyx
839.42	Sacrum Sacroiliac (joint)
839.49	Other

Appendix 4
Allowable Place of Service (POS) and Type of Service (TOS) Codes

Code	*Description*
3	Office

Code	*Description*
9	Other (including chiropractic office visit, adjustments, labs, and x-rays)
P	DME purchase (spinal supports)
R	DME rental (spinal supports)

Appendix 5
HCPCS and CPT-4 Procedure Code and Copayment Table for Chiropractic Services

Procedure Code	Description	Copayment
W6898	Chiropractic spinal support - purchase	$1.00/service
W6898	Chiropractic spinal support - rental	n/a
72010	Radiologic examination, spine, entire, survey study, anteroposterior and lateral	$1.00/procedure
72020	Radiologic examination, spine, single view, specific level	$1.00/procedure
72040	Radiologic examination, spine, cervical, anteroposterior and lateral	$1.00/procedure
72050	minimum of four views	$1.00/procedure
72052	complete, including oblique and flexion and/or extension studies	$1.00/procedure
72070	Radiologic examination, spine, thoracic, anteroposterior and lateral	$1.00/procedure
72100	Radiologic examination, spine, lumbosacral, anteroposterior and lateral	$1.00/procedure
72110	complete, with oblique views	$1.00/procedure
72120	Radiologic examination, spine, lumbosacral, bending views only, minimum of four views	$1.00/procedure
72200	Radiologic examination, sacroiliac joints, less than three views	$1.00/procedure
72202	three or more views	$1.00/procedure
72220	Radiologic examination, sacrum and coccyx, minimum of two views	$1.00/procedure
73000	Radiologic examination, clavicle, complete	$1.00/procedure
73010	scapula, complete	$1.00/procedure
73020	Radiologic examination, shoulder, one view	$1.00/procedure
73030	complete, minimum of two views	$1.00/procedure
73050	Radiologic examination, acromioclavicular joints, bilateral, with or without weighted distractions	$1.00/procedure
73060	humerus, minimum of two views	$1.00/procedure
73070	Radiologic examination, elbow, anteroposterior and lateral views	$1.00/procedure
73080	complete, minimum of three views	$1.00/procedure
73500	Radiologic examination, hip, unilateral, one view	$1.00/procedure
73510	complete, minimum two views	$1.00/procedure
73520	Radiologic examination, hips, bilateral, minimum of two views of each hip, including anteoposterior view of pelvis	$1.00/procedure
73540	Radiologic examination, pelvis and hips, infant or child, minimum of two views	$1.00/procedure

Procedure Code	Description	Copayment
73550	Radiologic examination, femur, anteroposterior and lateral views	$1.00/procedure
73560	Radiologic examination, knee, anteroposterior and lateral views	$1.00/procedure
73562	anteroposterior and lateral, with oblique(s), minimum of three views	$1.00/procedure
73564	complete, including oblique(s) and tunnel, and/or patellar and/or standing views	$1.00/procedure
81000	Urinalysis; by reagent strips, any number of components, with microscopy	$0.50/procedure
99201	Office or other outpatient visit for the evaluation and management of a new patient, which requires these three key components: a problem focused history, a problem focused examination, and straight forward medical decision making	$1.00/visit
W9010	Chiropractic adjustment	$0.50/procedure

Appendix 6
Prior Authorization Request Form (PA/RF) Sample

MAIL TO:
E.D.S. FEDERAL CORPORATION
PRIOR AUTHORIZATION UNIT
6406 BRIDGE ROAD
SUITE 88
MADISON, WI 53784-0088

PRIOR AUTHORIZATION REQUEST FORM
PA/RF (DO NOT WRITE IN THIS SPACE)
ICN #
A.T. #
P.A. # 1234567

1 PROCESSING TYPE
118

2 RECIPIENT'S MEDICAL ASSISTANCE ID NUMBER
1234567890

3 RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL)
Recipient, Ima A.

4 RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE)
609 Willow
Anytown, WI 55555

5 DATE OF BIRTH
MMDDYY

6 SEX
M ☐ F ☒

8 BILLING PROVIDER TELEPHONE NUMBER
(XXX) XXX-XXXX

7 BILLING PROVIDER NAME, ADDRESS, ZIP CODE:
IM Provider
1 W. Williams
Anytown, WI 55555

9 BILLING PROVIDER NO.
12345678

10 DX: PRIMARY
893.2 Subluxation of lumba

11 DX: SECONDARY
839.00 Subluxation of cervica

12 START DATE OF SOI:

13 FIRST DATE RX:

14 PROCEDURE CODE	15 MOD	16 POS	17 TOS	18 DESCRIPTION OF SERVICE	19 QR	20 CHARGES
W9010		3	1	Chiropractic adjustment	12	XX.XX
					TOTAL CHARGE	21 XX.XX

22. An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

23 MMDDYY
DATE

24 I. M. Provider
REQUESTING PROVIDER SIGNATURE

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION:

☐ APPROVED

GRANT DATE

EXPIRATION DATE

PROCEDURE(S) AUTHORIZED

QUANTITY AUTHORIZED

☐ MODIFIED — REASON:

☐ DENIED — REASON:

☐ RETURN — REASON:

DATE

CONSULTANT/ANALYST SIGNATURE

Appendix 7
Prior Authorization Request Form (PA/RF) Completion Instructions

Element 1 - Processing Type
Enter processing type 118 (chiropractic).

Element 2 - Recipient's Medical Assistance Identification Number
Enter the recipient's 10-digit identification number from the recipient's identification card.

Element 3 - Recipient's Name
Enter the recipient's last name, first name, and middle initial, from the recipient's identification card.

Element 4 - Recipient's Address
Enter the address of the recipient's place of residence; include the street, city, state, and zip code. If the recipient is a resident of a nursing home or other facility, also include the name of the nursing home or facility.

Element 5 - Recipient's Date of Birth
Enter the recipient's date of birth in MM/DD/YY format (e.g., June 8, 1941, would be 06/08/41), from the recipient's identification card.

Element 6 - Recipient's Sex
Enter an "X" to specify male or female.

Element 7 - Billing Provider's Name, Address and ZIP Code
Enter the billing provider's name and complete address (street, city, state, and zip code). ***No other information should be entered in this element since it also serves as a return mailing label***.

Element 8 - Billing Provider's Telephone Number
Enter the billing provider's telephone number, including the area code, of the office, clinic, facility, or place of business.

Element 9 - Billing Medicaid Provider Number
Enter the billing provider's eight-digit provider number.

Element 10 - Recipient's Primary Diagnosis
Enter the appropriate diagnosis code from Appendix 3 of this handbook that is most relevant to the procedure requested.

Element 11 - Recipient's Secondary Diagnosis
Enter the appropriate diagnosis code from Appendix 3 of this handbook that is additionally descriptive of the recipient's clinical condition.

Element 12 - Start Date of Spell of Illness (not required)

Element 13 - First Date of Treatment (not required)

Element 14 - Procedure Code(s)
Enter the appropriate HCPCS or CPT-4 procedure code for each procedure requested, in this element.

Element 15 - Modifier
Enter the modifier corresponding to the procedure code (*if a modifier is required by Wisconsin Medicaid policy and the coding structure used*) for each procedure requested.

Element 16 - Place of Service
Enter place of service code 3 (office).

Element 17 - Type of Service
Enter type of service code 9, P, or R for each procedure requested (see Appendix 4 of this handbook).

Element 18 - Description of Service
Enter a written description corresponding to the appropriate HCPCS or CPT-4 procedure code for each procedure requested.

Element 19 - Quantity of Service Requested
Enter the quantity (e.g., number of services, dollar amount) for each procedure requested.

Chiropractic (number of adjustments)
Durable Medical Equipment (number of services)

Element 20 - Charges
Enter your usual and customary charge for each procedure requested. If the quantity is greater than "1," multiply the quantity by the charge for each procedure requested. Enter that total amount in this element.

Note: The charges indicated on the *request form* should reflect the provider's usual and customary charge for the procedure requested. Providers are reimbursed for authorized services according to the Department of Health and Social Services' *Terms of Provider Reimbursement*.

Element 21 - Total Charge
Enter the anticipated total charge for this request.

Element 22 - Billing Claim Payment Clarification Statement
An approved authorization does not guarantee payment. Reimbursement is contingent upon the recipient's and provider's eligibility at the time the service is provided and the completeness of the claim information. Payment is not made for services initiated prior to approval or after authorization expiration. Reimbursement is in accordance with Wisconsin Medicaid payment methodology and policy. If the recipient is enrolled in a Wisconsin Medicaid HMO at the time a prior authorized service is provided, reimbursement is only allowed if the service is not covered by the HMO.

Element 23 - Date
Enter the month, day, and year (in MM/DD/YY format) the prior authorization request form was completed and signed.

Element 24 - Requesting Provider's Signature
The signature of the provider requesting the service must appear in this element.

.

Do not enter any information below the signature of the requesting provider. This space is used by Wisconsin Medicaid Consultant(s) and Analyst(s).

Appendix 8
Prior Authorization Chiropractic Attachment (PA/CA) Sample

Mail To:

E.D.S. FEDERAL CORPORATION
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

PA/CA

PRIOR AUTHORIZATION CHIROPRACTIC ATTACHMENT

1. Complete this form
2. Attach to PA/RF (Prior Authorization Request Form)
3. Mail to EDS

RECIPIENT INFORMATION

(1) LAST NAME	(2) FIRST NAME	(3) MIDDLE INITIAL	(4) MEDICAL ASSISTANCE ID NUMBER	(5) AGE
Recipient	Ima	A	1234567890	29

PROVIDER INFORMATION

(6) PERFORMING PROVIDER'S NAME	(7) PERFORMING PROVIDER'S MEDICAL ASSISTANCE PROVIDER NUMBER	(8) PERFORMING PROVIDER'S TELEPHONE NUMBER
IM Performing	12345678	(XXX) XXX - XXXX

Requesting prior authorization to extend treatment beyond twenty (20) Manipulations per spell of illness

1. Requesting 12 manipulations per month, over 6 months.

2. Recipient's history:

4. Objective findings:

When Ima was last seen on MMDDYY, she had tenderness over the L-S area, and muscle tightness for the quadratus laborum and over the right scaphoid region.

5. Recipient's subjective and objective progress:

Ima is able to go approximately two weeks before requiring a treatment. Immediately after treatment, there is a release of the muscle spasticity and associated pain.

THE PROVISION OF SERVICES WHICH ARE GREATER THAN OR SIGNIFICANTLY DIFFERENT FROM THOSE AUTHORIZED MAY RESULT IN NON-PAYMENT OF THE BILLING CLAIM(S).

MMDDYY
Date

J. M. Provider
Requesting Provider's Signature

Appendix 9
Prior Authorization Chiropractic Attachment (PA/CA)
Completion Instructions

Prior authorization determinations are enhanced by complete and high-quality documentation included with the request. Carefully complete this attachment, attach it to the Prior Authorization Request Form (PA/RF) and submit to:

EDS
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

Contact the EDS Policy/Billing Correspondence Unit with questions about completing of the Prior Authorization Request Form (PA/RF) and/or the Prior Authorization Chiropractic Attachment (PA/CA). The telephone numbers are listed in Appendix 2 of Part A of the provider handbook.

RECIPIENT INFORMATION:

Element 1 - Recipient's Last Name
Enter the recipient's last name from the recipient's identification card.

Element 2 - Recipient's First Name
Enter the recipient's first name from the recipient's identification card.

Element 3 - Recipient's Middle Initial
Enter the recipient's middle initial from the recipient's identification card.

Element 4 - Recipient's Medicaid Identification Number
Enter the recipient's 10-digit identification number from the recipient's identification card.

Element 5 - Recipient's Age
Enter the recipient's age in numerical form (e.g., 45, 60, 21).

PROVIDER INFORMATION:

Element 6 - Performing Provider's Name
Enter the name of the chiropractor who will provide treatment.

Element 7 - Performing Provider's Medicaid Provider Number
Enter the eight-digit provider number of the performing provider (the provider who will provide treatment).

Element 8 - Performing Provider's Telephone Number
Enter the telephone number, including area code, of the performing provider.

Use the remaining portions of this attachment to document the justification for the requested service to be provided.

1. Complete elements 1-8.

2. Read the Prior Authorization Statement before dating and signing the attachment.

3. Date and sign the attachment.

Appendix 10
Example Prescription for SMV Transportation

SMV providers must obtain prior authorization for all SMV trips (except for hospital and nursing home discahrges) that:

- originate in one of the urban counties listed below and exceed 40 miles one-way: and
- originate in any other county and exceed 70 miles one-way.[1]

Prior authorization requires a prescription from the referring provider.[2]

Urban counties are: Brown, Dane, Fond du Lac, Kenosha, LaCrosse, Manitowoc, Milwaukee, Outagamie, Sheboygan, Racine, Rock, and Winnebago.

If you refer a recipient who needs SMV transportation to a medical service that you suspect is farther away than the Wisconsin Medicaid upper mileage limits, write a prescription for the recipient to show the SMV provider.

Your prescription should include the name of the health care provider or facility, city where it is located, the service the recipient requires, and the amount of time the recipient needs transportation to the service (indicate time in days, not to exceed 365 days).

Example of Prescription for SMV Trips That Exceed Upper Mileage Limits

Anytown Clinic
1 W. Wilson
Anytown, WI 55555

Name J. R. Recipient

Address 609 Willow, Anytown, WI 55555

℞ Green Bay Regional Clinic
Consultation
7 days

Prescriber's Signature J. R. Referring, D.C. Date 6/1/95

[1]HSS 107.23(2)(f), Wisconsin Administrative Code

[2] Providers who may refer recipients and write SMV prescriptions are: Physicians, physician assistants, nurse midwives, nurse practitioners, dentists, optometrists, opticians, chiropractors, podiatrists, HealthCheck agencies, and family planning clinics.